STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3641HOS	A. BUILDING _____ B. WING _____	C 06/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN HILLS HOSPITAL & MEDICAL CEN	9300 WEST SUNSET LAS VEGAS, NV 89148

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 05/29/09 and finalized on 06/02/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00021536 was substantiated with deficiencies cited (Tag S143, S145, S146, S153). Complaint #NV00019281 was unsubstantiated. Complaint #NV00021888 was unsubstantiated. Complaint #NV00018874 was unsubstantiated. Complaint #NV00019723 was unsubstantiated. Complaint #NV00020328 was unsubstantiated. Complaint #NV00021639 was unsubstantiated. Complaint #NV00016460 was unsubstantiated. Complaint #NV00016019 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000	See Exhibit A, "Discharge Planning" See Exhibit B, "Discharge Planning Referrals" See Exhibit C, "Assisted Living / Adult Group Care Homes" See Exhibit D, "Adult Group Care Discharge Planning Tool" See Exhibit E, "Resident Compliance Evaluation Tool" The director of case management, Michelle Bogardus RN has written 3 new policies regarding safe discharge titled "Discharge Planning", Discharge Planning Referrals", and "Assisted Living/Adult Group Care Homes". These policies will be reviewed and approved at the July Policy and Procedure Meeting. The forms "Adult Group Care Discharge Planning Tool" and "Resident Compliance Evaluation Tool" will be approved at the July Forms Committee Meeting.	8/16/20
S 143 SS=D	NAC 449.332 Discharge Planning 1. A hospital shall: (a) Have a process for discharge planning that	S 143	RECEIVED	8/16/20 8/16/200

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Michelle Bogardus

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S 143	Continued From page 1 applies to all inpatients; and (b) Develop and carry out policies and procedures regarding the process for discharge planning. This Regulation is not met as evidenced by: Based on policy review and interview the facility failed to ensure a policy was in place regarding the safe medical discharge planning of a patient and the patient's needs when a family member, power of attorney (POA) preferred a lower level of care for discharge than was needed for the patients. Findings Include: 1. The "Hospital Wide, Admission, Discharge and Transfer" policy, dated 5/08, did not include a "Discharge Guideline" for a patients' safe medical discharge when the family or POA preferred a lower level of medical care than was medically needed/required for the patient. Interviews with the Director of Case Management and a Case Manager were held in the afternoon of 5/29/09. Both interviews indicated they were unaware of facility policies guiding the issue of the family or POA preferring a lower level of care than was required for a safe patient discharge. Both Case Managers were unsure what actions needed to occur to ensure the needs of the patient for a safe discharge. Severity: 2 Scope: 1 Complaint #NV00021536	S 143	All case management employees will be oriented to the new policies in an in-service, with a signature of understanding. The in-service will be provided by the case management director and social worker. Ten percent of the patients who have a discharge plan to a skilled nursing facility, long term care, rehabilitation facility, or assisted living/group home will be audited retroactively to ensure the new policies are followed and procedures within the policies are performed. The audits will be performed by the case management director, the social worker, and the registered nurse case managers. The audits performed by the registered nurse case managers will be subject to a second medical record audit by the director of case management or social worker. These audits will begin after the Policy Education In-service is completed.	8/16/20 8/16/20 8/16/20 8/16/200

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S 145	Continued From page 2	S 145	Any discharge to an assisted living facility or group home will be concurrent reviewed/audited by two or more licensed case management employees, ie. Registered nurses, and/or Social Worker, prior to patient discharge to such facility. 8/16/20	
S 145 SS=D	NAC 449.332 Discharge Planning 3. A hospital shall, at the earliest possible stage of hospitalization, identify each patient who is likely to suffer adverse health consequences upon discharge if the patient does not receive adequate discharge planning. The hospital shall provide for an evaluation of the needs related to discharge planning of each patient so identified. This Regulation is not met as evidenced by: Based on chart review, and interview the facility failed to identify a patient was likely to suffer adverse health consequences upon discharge if the patient did not receive adequate discharge planning for 1 of 9 patients (Patient #8). Findings include: 1. The patient's chart had several entries regarding her: "altered mental status", needing assistance with ADL (daily living skills), requirement of oxygen, wound treatment, the use of a Foley catheter, the need for a skilled nursing facility, the evaluation by an Adult Group Care (AGC) stating the patient was not appropriate for that level of care, an evaluation for a Home for Individual Care (HIC) stating equipment that would be required for safe care in that facility type, increased lethargy, unsafe to be left in chair alone, "bedfast", "total care", a pureed diet, a cardiac diet, contractures, confused, altered impaired knowledge, altered gross motor, impaired thought process, and was dependent on feeding. The patient was discharged to an AGC. This patient would not meet the criteria per State Regulations for an AGC. In addition, there was no documented evidence measures were put in place to address the patient needs for Oxygen	S 145	**Exhibit A "Discharge Planning"** • Tag S 143 • Tag S 145 • Tag S 146 • Tag S 153 **Exhibit B, "Discharge Planning Referrals"** • Tag S 143 • Tag S 145 • Tag S 146 • Tag S 153	

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S 145	Continued From page 3 care, Foley catheter care, movement/positioning care, wound care, proper equipment for care, ADL care, diet and nutrition needs, as well as feeding needs.. Interviews with the Quality Management Director and the Case Management Director indicated there was no documentation in the record stating needs were addressed nor planned for. The Quality Management Director indicated the Discharge summary and the Consent for transfer sheet goes with the transport. Neither of these contained referrals, prescriptions and patient needs to ensure a safe discharge with no adverse health consequences. Severity: 2 Scope: 1 Complaint #NV00021536	S 145	**Exhibit C, "Assisted Living / Adult Group Care Homes"** • Tag S 143 • Tag S 145 • Tag S 146 • Tag S 153 **Exhibit D, "Adult Group Care Discharge Planning Tool"** • Tag S 143 • Tag S 145 • Tag S 146 • Tag S 153 **Exhibit E, "Resident Compliance Evaluation Tool"** • Tag S 143 • Tag S 145 • Tag S 146 • Tag S 153	
S 146 SS=D	NAC 449.332 Discharge Planning 4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Based on policy review, chart review, and interview the facility failed to ensure an evaluation of the needs of the patient relating to discharge planning included the capacity of the patient for self-care and the possibility of returning to previous care setting or making another	S 146		8/14/2009

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S 146	Continued From page 4 appropriate placement after discharge for 1 of 9 patient (Patient #8). Findings include: 1. The Hospital Wide, Patient Care: Patient Assessment/Reassessment" policy, dated 10/06, stated: - page 4 and 5, case Management/Social Services. I.d. The scope of the Case Managers assessment includes "1. Functional and cognitive limits and needs, 4. Post discharge care needs." - page 5, "II Reassessment: a. Each patient is reassessed: ...2. When there is a change in the discharge plan, 3. When another referral is made by the physician or any member of the healthcare team." - page 5, "III Communication with the Healthcare team: a. The case manager records communication and documents in the interdisciplinary ..." 2. Hospital Wide Initial Patient Status Assessment, dated 3/2006, pg 2 stated: -C. Nursing staff obtains orders for observation, admission or discharge at appropriate times and based upon medical necessity. -E. Case Management (CM)/Social Services (SS) staff reviews status changes for appropriateness based on interqual criteria for medical necessity and for appropriateness of physician's order. -H. CM/SS staff provides discharge planning in	S 146	See Pages 1-4 8/16/2009	

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S 146	Continued From page 5 consultation with the attending physician. There was no documented evidence the Case Manager completed an evaluation that included the the functional and cognitive limits or needs of the patient. There was no documented evidence the Case Manager (CM) completed an evaluation when there was a change in the discharge plan (from a Skilled Nursing Facility, SNF, to an Adult Group Care, AGC, facility) that included the functional and cognitive limits or needs of the patient. The CM documented the daughter made arrangements with an AGC and made transportation arrangements. The CM did not communicate in the notes the needs and abilities of the patient. 3. The patient's chart had several entries regarding her: "altered mental status", needing assistance with ADL (daily living skills), requirement of oxygen, wound treatment, the use of a Foley catheter, the need for a skilled nursing facility, the evaluation by an Adult Group Care (AGC) stating the patient was not appropriate for that level of care, an evaluation for a Home for Individual Care (HIC) stating equipment that would be required for safe care in that facility type, increased lethargy, unsafe to be left in chair alone, "bedfast", "total care", a pureed diet, a cardiac diet, contractures, confused, altered impaired knowledge, altered gross motor, impaired thought process, and was dependent on feeding. The patient was discharged to an AGC. This patient would not meet the criteria per State Regulations for an AGC. In addition, there was	S 146	See Pages 1-4 8/6/2009	

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S 146	Continued From page 6 no documented evidence measures were put in place to address the patient needs for Oxygen care, Foley catheter care, movement/positioning care, wound care, proper equipment for care, ADL care, diet and nutrition needs, as well as feeding needs.. Physician's orders: 3/9/09 - CM for Discharge planning 3/12/09 - transfer to Skilled Nursing Facility (SNF), if OK with consultants 3/13/09 - Group home bed, Home for Individual care (HIC) home. There was no documented evidence the CM discussed the levels of care and patient care needs with the physician. In an interview on 5/29/09 with the CM, she could not recall if she discussed with the physician that the family found an AGC for the patient. Interviews with the Quality Management Director and the Case Management Director indicated there was no documentation in the record stating needs were addressed nor planned for. The Quality Management Director indicated the Discharge summary and the Consent for transfer sheet goes with the transport when the patient is discharged. Neither of these documents contained referrals, prescriptions and the needs of the patient to ensure a safe discharge with no adverse health consequences. Severity: 2 Scope: 1 Complaint #NV00021536	S 146	See Pages 1-4	8/14/2009

Bureau of Health Care Quality & Compliance

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S 153	Continued From page 7	S 153		
S 153 SS=D	NAC 449.332 Discharge Planning 11. The patient, members of the family of the patient and any other person involved in caring for the patient must be provided with such information as is necessary to prepare them for the post-hospital care of the patient. This Regulation is not met as evidenced by: Based on policy review, chart review, and interview the facility failed to ensure persons involved in the post hospital care of the patient were provided the information necessary to safely care for the patient after discharge for 1 of 9 patient (Patient #8). Findings include: 1. There was no documented evidence the CM reviewed the functional/cognitive assessment of the patient nor the medical needs of the patient with the accepting facility (an Adult Group Care (AGC). 2. The CM documented the daughter called the AGC and the AGC said there was a bed available for the patient. The CM did not document if the needs and abilities of the patient were discussed with the AGC. 3. In an interview on 5/29/09 with the CM, she could not recall if the AGC came to the hospital to interview and obtain the needs of the patient nor if she discussed the needs of the patient with the AGC. 4. The patient was discharged to an AGC. This patient would not meet the criteria per State	S 153	See pgs 1-4	8/16/2009

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S 153	Continued From page 8 Regulations for an AGC. In addition, there was no documented evidence measures were put in place to address the patient needs for Oxygen care, Foley catheter care, movement/positioning care, wound care, proper equipment for care, ADL care, diet and nutrition needs, as well as feeding needs.. 5. Interviews with the Quality Management Director and the Case Management Director indicated there was no documentation in the record stating needs were addressed nor planned for. 6. The Quality Management Director indicated the Discharge summary and the Consent for transfer sheet goes with the transport when the patient is discharged. Neither of these documents contained referrals, prescriptions and the needs of the patient to ensure a safe discharge with no adverse health consequences. Severity: 2 Scope: 1 Complaint #NV00021536	S 153	See pages 1-4 8/10/2009	